MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
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COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
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RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM:
Private insurers' strategies for purchasing imaging services - Kevin Hayes

DR. REISCHAUER: Good morning. For those of you who were not here at the executive session, Glenn Hackbarth, the chairman, is testifying before the Ways and Means Subcommittee on Health and will be here this afternoon.

The first session that we have this morning deals with private insurers' strategies for purchasing imaging services. We have a distinguished and very knowledgeable panel that Kevin will introduce and set up with any introductory material that is necessary. Kevin?

* DR. HAYES: Thank you. We are really starting off here with two sessions which concern purchasing strategies. These are strategies used by private insurers and others to improve efficiency. By that we mean reducing spending while maintaining or improving the quality of care. So our first session will focus on imaging services.

Just by way of context, we wanted to give you a brief overview of how Medicare pays for imaging services under the physician fee schedule, just to give you a frame of reference for interpreting what the panelists have to say.

We also distributed for you an article that appeared in the New York Times on Saturday, a timely article that addressed imaging services, specialties of physicians providing those services and the fairly rapid diffusion of imaging equipment in, I believe it was in Syracuse.

So moving on then to this overview, we can begin first by just looking at the types of imaging services that Medicare pays for and we see them arrayed here in different categories of services, computed tomography, magnetic resonance imaging, echocardiography, other echography or ultrasound services, nuclear medicine, standard imaging which is essentially plain film x-rays, chest x-rays, and x-rays of the musculoskeletal system, that kind of thing. And then a category here, a small image called imaging procedures, which is more invasive things like cardiac catheterization and angiography.

You can see fairly even distribution among the categories in roughly the 12:00 o'clock to 9:00 o'clock of this, all ranging in the area of 11 percent to 17 percent of total spending. But standard imaging is one of the bigger categories at 23 percent of total spending and then that imaging procedure one is kind of small.

Services are provided by physicians in different specialties. This is all payments for services under the physician fee schedule. We can see here that radiology is a very

key specialty with payments approaching half of the total. Cardiology is another important specialty here, close to one-quarter, and then other categories shown as you can see there.

For purposes of payment we can categorize, we can decompose, break down imaging services into two components. One is a professional component, and that would be the portion of the service usually provided by a physician. It includes supervision of the imaging study, interpretation of the results, and preparation of a report. Then there's the technical component of the service which is the work of a technician, use of the equipment, supplies, that kind of thing. So it is possible for separate billing for each component or for both together, and that is what it meant by this global service that you see here.

This is a count of units of service so obviously there are some technical components missing here. The other technical components that you do not see here are the ones that are provided in a facility setting; hospital outpatient department. Even if a patient receives an imaging service as an inpatient, results still need to be interpreted so that is not shown on here but just something to keep in mind as part of the imaging services that beneficiaries receive.

One thing you will hear about during the panel discussion has to do with an issue having to do with multiple imaging services appearing on one claim for payment. So this is one example of that phenomenon. We see here computed tomography services, roughly 60 percent of the claims include one service, but the other 40 percent include two or more services. Sometimes payers make an adjustment for the second and subsequent services in terms of payment. The idea here being that there are some efficiencies associated with providing more than one service during a single encounter. Medicare is doing this kind of thing already with respect to surgical services but not with respect to other services.

A final point to make has to do with coding edits. These are rules, essentially, that are implemented observed during processing of claims and they detect during automatic claims processing any improperly coded claims. Examples of that would be one service on a claim that is actually a component of another service that's on that same claim. So these coding rules would detect that. This is all part of an effort, fairly transparent effort on the part of Medicare called the correct coding initiative that allows for clinical input in the process of establishing these coding rules.

We checked with CMS and they asked the carriers who process the claims to keep track of savings associated with these edits and they reported to us that the savings totaled $333 million in the year 2002 which is approaching about 1 percent of total spending.

What you will hear from the panelists is that they too use edits like these. In fact some of them actually use the CCI edits, but then they couple that with some other edits as well. Instead of just looking at pairs of codes that appear on the claims they might look at other information on the claim like the sex of the beneficiary or diagnosis. This is a way that they implement any kind of payment adjustments for second and subsequent services that are reported on a single claim.

So that's it in terms of just a quick snapshot, overview of how Medicare is paying for imaging services. I can answer any questions but we want to also keep an eye on the clock here and allow plenty of time for the panel and the discussion that follows.

MS. DePARLE: This is a very basic question. On your first slide, Kevin, where you break down the distribution of spending among types of services, I realized -- I thought this was in the text but I didn't see it -- that I'm not sure I understand what standard is versus CT, MRI. I understand procedures and how they're different, but what is standard, the 23 percent standard?

DR. HAYES: The 23 percent standard, the standard services are essentially plain film x-rays, chest x-rays and that kind of thing.

MS. DePARLE: Thanks.

DR. ROWE: This information is very nice and sets the stage for the discussion. If you have a chance it would be interesting to see what some of the trends are over time. These are kind of a cross-sectional look at the distribution, and it would be helpful to see where the growth is in dollars or in volume or in unit price, and just over every other year for the last six years or eight years or something like that so we can get a sense of what the opportunities are.

DR. HAYES: Sure. I can recall some of those details for you. We look at growth as part of our assessment of payment adequacy for physician services and what I recall from the analysis we did for the March report was that in the areas of CT and MRI we see growth there in the area of 15 percent or more per year per beneficiary.

DR. ROWE: Dollars or volume?

DR. HAYES: This is volume. That's volume in the sense that it's both the units of service as well as any changes in coding, intensity, or in the intensity of the service. So we're at 15 percent, 17 percent, whatever it might be in the case of CT and MRI. Echocardiography is right around 9 percent, nuclear medicine is somewhere, it's either in the 10 percent, 15 percent area, something like that. Standard imaging is very low, more in the 4 percent area I would say. And I just don't remember the imaging procedure.

DR. ROWE: Thanks.

DR. REISCHAUER: Kevin, do you want to introduce the panel?

DR. HAYES: I would like now to introduce our panelists. We have with us today Miriam Sullivan, who is the director of Allied Health Services for the Tufts Health Plan which serves Massachusetts and parts of New Hampshire and Rhode Island. We also have with us today Tom Ruane, who is the medical director of PPO and Care Management Programs for BlueCross BlueShield of Michigan. And third we have Cherrill Farnsworth who is the CEO and chairman of the board of HealthHelp Incorporated. HealthHelp is a radiology benefit management company providing services to a number of payers. So I'll turn things over to the panel and then we'll have a discussion to follow. We'll begin with Miriam.

MS. SULLIVAN: Thank you very much for the opportunity to be here this morning. I think Kevin's opening comments were a nice dovetail to the experience that we've had at Tufts Health Plan and I thought what I'd like to do today is walk you through some of the key reasons and drivers that we addressed imaging, some of the historical approaches we use, some current considerations, and lastly, just briefly touch on lessons that we have learned.

Essentially one of the key drivers that we formed a task force within our health plan was rising concerns about not only the cost but also the utilization trend as it related to overall diagnostic imaging. During 2000 to 2003 we saw a 48 percent increase in advanced imaging procedures, CT, MRI, nuclear cardiology, and PET scans. A majority of that 48 percent was made up by MRI and CT. That was 90 percent of that increased trend. Collectively, as we looked at our medical trend evaluation across the organization, radiology quickly jumped to number five of the top 10 key cost drivers. In addition, we were seeing different avenues, requests and demand for compensation payment and delivery of diagnostic imaging services and procedures in traditional settings that we had not previously seen before. Our historical approach up until then was comprised of a number of things. We have had a provider privileging program for approximately eight to 10 years where we privileged physicians in subspecialties to be able to before imaging services, and throughout the tenure of that program we have enhanced that and expanded that and feel that we have had great success with that.

Secondly, from a contracting perspective we went throughout our entire network and really looked at where were the services being provided, where were the opportunities, and we went and recontracted with our entire network and really expanded the freestanding service providers and found that there was opportunity not looking for access but also more innovative and creative ways to be able to structure some reimbursement methodology. So that was also part of this 13-month initiative that we concluded in 2003 and continues in '04.

I will skip for a minute to our radiology advisory committee. They've also played a vital role. We have a group of practicing radiologists throughout our network with specific subspecialties that we have chosen to be able to get a global and unique perspective about what they are seeing in their practice and also help guide on the clinical programs, protocols, et cetera.

Lastly, during 2003 we made a concerted effort to look at utilization management programs and vendors, and we have spent significant time evaluating those and at the end of that analysis we chose not to pursue that angle for a number of reasons, but the salient points I believe was, number one, in terms of the vendors that we selected for the RFP process we found that the costs associated with that contain some duplicate nature of what we had already implemented at the plan. And in addition we heard intense feedback from not only the member and the provider community that we use that the role of the traditional gatekeeper method within an HMO product, Secure Horizons was our Medicare+Choice program, was a significant loud and clear message that they did not see that role.

We understood that there would be some political pushback from that so what we did was we engaged them in a conversation to say, if not that, what would you be willing to work with and how can we come up with a strategic approach that will help us stem the utilization of also be transparent to the members and reduce some of what the perceived hassle factor was for the physicians?

So essentially from that 13-month initiative hat we found is it really -- our key findings fell into three specific areas. The increase consumer demand. We heard loud and clear that our members want access and choice. They want to be able to, as they are more informed in their health care decisions, they absolutely want to be able to have access and convenience in seeking out, and that's no different for diagnostic imaging.

We also worked very closely with our employer groups, and it was interesting over the past two years where the cost of pharmaceuticals and all of the well-documented experience with those trends, that radiology actually rose to the top of their list ahead of pharmaceuticals as wanting to know what were interventions that were going to be put in place to help drive and monitor those costs and mitigate the trend.

We found a real parallel between the direct-to-consumer marketing of pharmaceuticals similar to the be well body scans, give your family members and friends gift certificates over the holidays. We had a large marketing blitz in the Boston area and we had significant feedback that people were feeling me-too, the worried well, that type of approach, that we definitely heard that and it was resonating in more frequency.

The second was just the proliferation of imaging equipment.

We have seen significant expansion in the hospital outpatient departments, significant -- and I think depending on what side of the coin that you sit on, there is often documented reports about the lack of radiologists. In the Boston area there's been a number of studies linking, is it a true lack of radiologists or is it also keeping up with the capacity and increased utilization? We're also following some of those studies closely because I think there's some merit in terms of the trend mitigation.

Lastly, we have seen over the past 18 months, significant increase in physician-owned imaging equipment as the cost -- it's almost two ends of the spectrum. The hospital outpatient are purchasing the newest technology, large expensive equipment, and as the technology comes down to smaller size and cost that would fit well within an individual or an independent delivery networks, the physicians are looking to be able to purchase that as well.

Lastly, were the varied referral patterns, the clinical protocols that we evaluated. What was the referral process for people who physicians were vending services; hospitalized outpatient versus a freestanding facility? The second bullet, the distinct member receiving repetitive testing is extremely concerning to us. Our clinical and medical directors team are part of an evaluation with that. It should be noted for oncology, PET scanning, mammography, all of those screens that we would want people to seek were excluded from this.

We looked at people with diagnosis of maybe knee pain, knee strain, ankle strain, we looked at people who were having testing ordered even before a physician was evaluated. So they would call the office to say that they had some discomfort. The office staff would order imaging series. They go to the PCP's office and would have one of those procedures done. They then might be referred to an orthopedist who might do another battery of tests, and so on. When we really drilled into the data and saw the numbers of tests that distinct members were having, that was extremely concerning to us.

That led us to take a step back and look and see, rather than do a quick hit or a reactive approach, that we really wanted to take a step back and look at what were all the driving factors that influenced the increased utilization of diagnostic services. As you can see on this slide indicated here, we thought that there was really a number of forces but we found that they were well-situated into four buckets.

First, the consumer demand, the worried well. We heard from a focus group of physicians who say that there is significant pressure at the office to say, I want this procedure, I want this test. So it's a new development and that's where we saw the parallels with the pharmaceuticals about the me-too drugs. So

that was one component. And the education and safety around that.

Secondly, the provider payment policies that we engaged our physicians and our freestanding facilities to actively seek and look at opportunities so that we didn't need to do a broad brush approach and we really wanted to incent the physicians that were using high-quality centers, appropriate protocols, and not paint a broad brush, especially where the physicians who were meeting the goals and objectives that we were looking for. I'll speak in a minute to some of the performance measures and contracting initiatives that we embarked on in the past six months.

We also looked at benefit design and member cost-share, looking at steerage to more cost-effective facilities. In terms of benefit design, at least in the Boston area in the local markets we don't see a lot of cost shifting to the members in terms of copays or coinsurance for imaging services yet but it's something that's been talked about at length.

Lastly, our clinical coverage policy decisions, how do we meet the challenges of new technology, is the new technology more efficacious than existing or is it a case of, in some instances that is appropriate but in others new necessarily isn't always better? So what we've looked to do is enhance our existing privileging program, expand the credentialing requirements, and also expand our radiology advisory board with specialties in specific areas to help guide us in those procedures as well.

So the result of this is that we have just recently kicked off a corporate-wide imaging steering committee. We found that without the assistance and the help from a clinical perspective, contracting perspective, and a benefit design perspective, all of those components could help us achieve the ultimate goal that we were looking for. We also wanted to have a higher body from our senior leadership level to be able to gauge the effectiveness and understanding the trends in marketplace change, so how can we be effective in monitoring that? So this committee will be charged with approving the strategic goals, overseeing the policy development, and also monitor the execution of those key initiatives relative to diagnostic imaging.

The current initiatives that we have underway, as you can see listed on the slide, really are five-fold. One was provider payment restructuring. We have entered into alternative reimbursement methodologies with our providers. We've created incentives for preferred imaging facilities, whether it's access, more ease to schedule for membership, volume for steerage of membership to our identified or preferred providers.

We've also looked at clinical coverage guidelines and we have a team of medical directors that evaluate, along with our radiology advisory committee, and develop policies around the emerging technology and set guidelines for expansion of services

into non-radiology settings. I think one of the things that was notable for the Tufts Health Plan is we were getting consistent calls into our medical directors from physicians who said, I took a weekend course on ultrasound-guided biopsy, is this covered under your plan or benefit design? We just started to tally what people were asking for and realized that there was real need and a real commitment to be able to set guidelines to ensure quality and have a philosophical approach from our plan's perspective.

We also looked to enhance our privileging program. We do site visits and do credential all of our imaging facilities, and we have worked with radiology consultants to go out and really scan the equipment on a more frequent basis, tie it to coding to make sure that we are maximizing the way that the centers are billing it and coding accordingly, and also use the enhanced privileging program to endorse the physician education surrounding clinical appropriateness and testing and really get our physicians and the radiology advisory committee to work hand-in-hand with our network physicians.

Probably the most novel and creative change the we've experienced at the plan are performance measures. When we had spoken about the utilization management programs we heard loud and clear that the physicians did not want that gatekeeper. We did focus group with some members along a number of UM programs not just solely related to diagnostic procedures, and what we did was we looked at what would be a benchmark across our network. We evaluated the performance of all of our physician groups and saw where they fell above that utilization network and where they fell below. What we were surprised to find is that it is very focal and there are pockets of where the utilization is driving a lot of the trend.

So what we have adopted are focal risk arrangements to be able to give incentives to physicians to get them to actively monitor the key drivers of trend, of which radiology is just one of those areas. We have actually seen some great success with that.

Lastly, the member education. We are embarking on an education campaign highlighting the risks and benefits of repetitive testing. One of the things that we thought this dovetailed with, our launch of a new consumer-driven health product in January of this year where this product enhances members to get preventative screening and hospitalization where needed, and gives them incentives and healthy rewards. But it also takes away some of the cloudiness around reimbursement structures. So we're providing transparency around the true cost of these procedures. And as it relates to a discretionary procedure, giving them the information and the education so that they still have the opportunity to make that decision, but we want it to be an informed decision that they make.

Lastly, as a result of this we felt that from the Tufts Health Plan perspective we wanted a strategic long-term approach to look at the delivery of diagnostic services, understanding that there will be continued new technology, that the landscape may change, product design will change, and really the hallmark of our approach is relegated to ensuring that our membership have access to quality care while balancing the intensified pressure for cost controls.

We hear that in an increasing basis, that we wanted a way to effectively manage the proliferation of that new technology and have clinically sound protocols for addressing that. But we also wanted to ensure that we had member education and satisfaction, and lastly, achieve physician engagement by offering incentives and decreasing the hassle factor which in the past was really a deterrent for helping us achieve that trend. We are approximately six months into this latest initiative but we have had great success.

DR. REISCHAUER: Thank you.

Dr. Ruane.

DR. RUANE: Thank you. I am always jealous when I'm on a panel with someone from a real managed care program, all the tools that they have at their disposal to manage costs, and we have so little in my health plan. But that's another story.

I was invited here today I think to really talk about the practical application of three programs that we use at BlueCross BlueShield of Michigan PPO programs that we believe have had an impact on moderating the increased cost of radiology services. I'll spend a few minutes talking about that, but I have to give you just a bit of background in terms of who we are and why we made the decision to do the programs that we did to, again, put these in context.

BlueCross BlueShield of Michigan is a large, single state, not-for-profit Blues plan. We have just under 5 million members. We have a history -- our success over the past 50 years has really been in the administration of a traditional indemnity insurance type product. That is regulated quite tightly in the state of Michigan by a specific public law that does apply to all non-profit large health insurers but we are the only ones, so we believe it's our own personal law. It really limits what we can do.

It requires us to allow every physician with an active license to participate in our plan, and it requires us to have equitable payment policies so that we have a single fee screen for all participating physicians. It also requires us to pay for, in general, all of the services that are within the scope of practice for a particular physician. So that really gives us very limited opportunity to manage apparently. But some things that happened that have changed that a bit.

Our business has migrated to a PPO structure within BlueCross BlueShield of Michigan and we believe that under the PPO structure we do have some more latitude in terms of what we can do in terms of managing health care. But we also really are well aware that both our doctors and our members really like many of the aspects of their traditional coverage, and we are really committed to preserving that. So although we are a PPO structure, we have 90 percent of the physicians in the state participating with us.

We also do not have any primary care physician assignment or control of referrals within our PPO network, and we do, from the physician side, do operate on a single fee screen for all physicians. We really have done minimal limitation of types of services available that each individual physician can provide. So that's the context. We are, again, not a managed-care organization competing with several others in a relatively mature market. We're much closer to the way that Medicare is actually administered.

I won't spend any time on this except to indicate that in general 10 percent of the health care dollar goes to imaging; about 20 percent annual trend. Just for rule of thumb, all two-thirds of that goes to high-tech procedures and about one-third goes to low-tech office-based procedures. This is the pie that Kevin showed you only sliced in two pieces. The trend, and I think there is general agreement that the trend on the high-tech imaging side is really higher.

What drives the trend? I think the number one driver of the trend is technological advancement. These are wonderful tests that are available that really have improved the care of patients. Our fundamental business is making these tests available to people. It really should go against the grain to be talking about limiting access to these tests and it really does. I think we really have to keep in perspective the fact that we really want to make these tests available without unnecessary or improper barriers.

The other things that drive trend are medical inflation, capacity, availability of the test. Anything you have to wait in line a long time for will be delivered less frequently. But the big piece that we believe, it's sort of the intellectual underpinnings of all of this work is that there is widespread practice variation among physicians and that it is not related to differences in the patients that they see and the illnesses that they treat. It really is related to differences in practice style.

Again, among those things that cause that variation are different degrees of concern about defensive medicine. I think that's a genuine concern of most physicians, but it's also maybe an excuse to act out for other physicians who are so annoyed with

this prospect.

Follow-up of previous positive tests. There is nothing more annoying than having a $500 test that was not necessary and finding some odd thing that requires a $1,000 test to the make sure that it really does not mean anything. So I think it is important to not get into that kind of cascade.

Our doctors tells us that patient expectations are important and what are they to do? Their patients are demanding these tests and sometimes they tell us that they are demanding those tests because they're standing right in front of them with their advertisement and their Val-Pak coupon for the discount demanding this particular test. So that's really an interactive issue.

Then finally, self-referral. This is a topic for another day, obviously, but the extent to which the tests that a physician decides on and orders for the care of his patients or her patients actually results in benefit to that physician is a real difficult issue in medicine across the board, particularly in imaging. The Medicare program and the federal government have written wonderful draft guidelines on self-referral that I think have really moved the discussion on this forward, but reaching consensus on even definition and appropriate action across-the-board is more difficult. But I think I would say that self-referral is just the key to many of the issues that we are dealing with here.

I think just one thing I want to say about why in our situation we would do management of radiology services, because I think there is a temptation to say, this is wonderful stuff. Most of it's good. It's not cheap. It's not easy to do anything about the cost. Sort of, let the good times roll, let the market sort this out, and maybe at the end of the year we will be able to, if we have high cost and utilization we'll be able to decrease the price a bit. I think that approach might or might not work. It has it's own pros and cons to it.

But it's simply not an option for us. Many of our customers are large businesses and over the past 30 years they have been challenged and they've gone through wrenching changes to deliver higher-quality products at lower costs. They just are not going to listen to that type of an argument, let the market work. They have done very difficult things internally and they've imposed their quality improvement processes on their suppliers as well. So we are a major supplier for those companies and they are really visiting us every day wanting to know what we're doing actively to manage care, to deliver value for the money.

I because that if you think about it, if we are able to save $3,000 or $4,000 in our market, that funds the health insurance for a worker who otherwise might not have it, it allows a company to honor its commitment to a retired worker who is Medicare age for health insurance, and to honor their commitment for a drug

benefit for, or Medigap benefit for their retired employees. So it's very serious business and we have to have very specific answers as to what we're doing.

Three programs that we do. We require precertification of high-tech, high-cost procedures. That's the slice of the pie related to that that's growing most rapidly. Privileging; Miriam mentioned. We restrict payment for specific procedures to particular specialists or provider types. Then thirdly, we include some general cost profiling of our physicians' performance in our PPO panel and a large piece of that really has to do with imaging variation, which I'll mention briefly when I get to that.

This is a parts where I'm telling Cherrill her business, so I don't think you can see if she kicks me, but I'll let you know if that happens. But precertification is a process whereby we require preauthorization of relatively expensive procedures. It really makes sense to do this. These procedures often new. They're ordered by every physician and the indications for particular procedures are not always known by the physician in practice. A new technology might become available that would, even though more expensive is now the appropriate test, and we don't want a physician ordering an inappropriate test, even if it's less expensive and then needing to do the better test later on. So we think there is an opportunity for education in this environment. So that's one of the reasons this makes sense.

For the program to work what you need is the providers of the radiology services have to believe that they will not receive full payment unless an authorization accompanies the claim that they send to BlueCross. So when the doctor wants to order a particular test that comes under this program, his office calls the imaging facility, tells them it's a BlueCross patient. They need to say, we'll need an authorization number. The doctor then calls the precertification agency and obtains that authorization number.

That, again, is an interaction that does come with some cost. It comes with a cost actually for the health plan to hire a vendor to do that, which I think is really pretty necessary in this age. And then it comes at a second cost to the doctor who needs to do this, even though he, the ordering physician, is not in the game in terms of payment for the procedure.

But I think there are pros and cons to this particular program. The pros are, it doesn't raise regulatory issues. It doesn't restrict the scope of practice of any physician for ordering, or any radiologist for performing the procedure. It simply requires this precertification step. The quality improvement component I've mentioned. We do find that a significant period of time physicians are ordering the wrong test and our radiology management program helps to get the right test

done.

But it works in the longer run by changing physicians' practice pattern. When I call and want to order an MRI for someone's back pain that they've had for four days and they don't have any sciatica or other things that make it particularly worrisome, once I call once and get that precertified and they say, you know, doctor, the standards are that if this pain is recent, if there aren't any complications, you really can delay imaging for several weeks. I will not call the next time I have a patient in that situation. I'll learn those criteria and I will likely wait a bit longer or look for specific findings before I would order that test, that again, medical consensus would regard as unnecessary at that point.

Than an additional benefit of this program is it monitors for new technology and novel applications for existing technology. We can get three claims for a CT scan of the abdomen, a CT scan of the pelvis, and a radiology claim that relates to a computer construction of an image and the diagnosis is abdominal pain. We'll typically pay that.

In our precertification program we will learn when the doctor calls up to precert that that's a virtual colonoscopy. There is not a code for that yet so it pays under existing codes. The vendor that we use can tell the doctor that this is not an approved technology at this point for our health plan and not approve it. So that is an unanticipated spinoff, a benefit of the program.

On the negative side, these are expensive and specialized programs that you few health plans could carry off on their own. They do require vendors doing very high-quality business. It adds a non-reimbursed administrative expense to the ordering physician for every study. Then finally, because it works mainly by the effect of educating the physicians and telling them what the criteria are, you lose the high rate of denials very quickly, even if you do see them. So it is difficult to document internally for us to justify the continued expense of these programs when we don't see a big difference in trend. We do see some difference but we don't see a big difference in trend from year-to-year.

But I think in the main we believe that this is an effective program. We think that the charge that we need to give to our radiology vendor in this program is to absolutely minimize the interaction cost for the appropriate procedure. Get that down to nothing if they can. They are able to use telephonic, fax, and web-based technologies to really reduce those costs and increase volume. And then secondly, to really have available when the doctor calls, if the test is questionable, an appropriate specialist to really guide them in the right direction. Both of the those things can be fairly expense to carry out.

Privileging is the restriction of payment defined to particular specialists. We do have this program in our PPO program. We don't apply it to a terrific number of procedures. Radiologists are paid for all studies, and then appropriate specialists are paid for specialized studies. The main impact of this is that it does eliminate high-volume, low-quality non-invasive studies in the primary care physician and podiatrist's office. Doppler, ultrasound, echo kinds of studies really are in that situation. And then nuclear cardiology is a very high-volume, high-cost procedure that we really do not want to see disseminating out of the specialist environment.

Pros and cons of privileging? It is relatively inexpensive but it does require accurate specialty and provider type listing in a computer file that your payment file can talk to. If you have not paid in a health plan anything based on specialty before you might be surprised that you don't have that. We were surprised that we didn't have it when we tried to implement the program, and it does require some work to get those systems talking.

It eliminates high-volume, low-quality studies. The diagnostic equipment that becomes somewhat obsolete in our tertiary medical centers often does not go to the Third World. It often goes down the street to another doctor's office where it lives another life.

Against the privileging, it really does restrict for services within the scope of practice of a physician, something that physicians are very sensitive about. It may limit access in a rural area, and we have exempted our rural counties from this program to deal with that. And it's a blunt tool. There are primary care physicians out there who do these tests only when they're absolutely necessary and do a fine job, and unless we want to get down to the even much more expensive proposition of privileging them individually, which again, our overhead doesn't permit us to do, we impact them as well and we really wouldn't want to do that in a perfect world.

The final thing I'll mention very quickly is that within our PPO program we profile the cost of care for each of our physicians within a number of specialties. We haven't figured out how to do it for everyone, but we do it for primary care physicians, allergists, dermatologists. We're doing it for pain medicine specialists now and a few other groups. We look at the ones whose cost of care is substantially higher than their peers, and we identify and notify the high-cost outliers of the pattern. Again, when we send them a letter saying, the cost of care in your practice is pretty high, we find that that has been generally ignored and had no impact.

But our current letters say, because costs of care in your practice is very high our credentialing committee has voted to

remove you from our network. Then the rest of the letter tells them how they can stay in. Those letters do get some attention. So the possibility of sanctions has to exist, not just on paper, but in the physician's mind.

Pros and cons of profiling are that the process clearly focuses on the bad apples. When physicians object to administrative cost of doing precertification or losing of clinical privileges they always say, I'm a good doctor. Why don't you go after the bad apples? This is a program that really does focus on people who are at least statistically inordinate utilizers of various procedures.

It can be applied to many procedures. We find that imaging is always a major contribution to cost of care in our primary care specialty areas. But it does apply to things that we see a lot that you folks are not as concerned about like acne surgery, but also physical therapy; a number of procedures that can put people in this situation.

The other positive thing is that the impact is usually correction. Eighty percent of the time when we notify a physician of this type of practice pattern, within two years they are within peer norms, which we regard as within 25 percent of the peer group in terms of average payment per patient. So the impact is usually correction. The need for disaffiliating doctors from the network is much less than you might anticipate.

On the con side, it's something that you can't do without a large database for comparison. It's time-consuming and confrontational. It's the opposite of precertification which really is best done by a highly specialized organization. This really can only be done by someone that does it every day within the health plan. The have to understand what's going on in Flint, Michigan, and Saginaw, Michigan and Grand Rapids, Michigan and our various issues around access and specialty really to do this appropriately. So it's not an easy procedure.

Then it must consider reasonable practice variation and risk adjustment. The physicians want to have us adjust their data to compensate for the fact that their patients are sicker and all of the other reasons that physicians believe cost is high, and we aren't able to do that electronically, but we do do that on a one-on-one basis, and then physicians are very sensitive to this type of sanction.

Methodologically complex to say what the outcome is, but we believe that we achieved initially an absolute 10 percent reduction in cost of outpatient imaging at the beginning of the program and a slightly lower continuing trend that results in somewhere between a 20 percent and 30 percent difference between what we would have experienced in managed care and what we have in our PPO.

Just three bits of information that talk about this self-

referral, just if you are concerned that it might not really exist. There's publications that show selected imaging costs four to seven times higher when they're provided by the ordering physician, even when the services are readily available outside the doctor's office. That makes a big difference. We have one experience where neurologists owning an MRI equipment resulted in 30 percent higher community-wide utilization. And then our radiology vendor has told us that they managed two areas next to each other, adjacent areas, where the nuclear cardiology procedures are twice as high in the environment where the cardiologists own and operate the nuclear imaging machines compared to similar environment where those are in the hospitals and the cardiologists don't have a financial stake in the use of that equipment.

Thank you.

DR. REISCHAUER: Thank you. Ms. Farnsworth.

DR. HAYES: Let me, if I may, just check on our time here. We are scheduled to go until 11:30. Cherrill has a 15-minute presentation. Is it okay if we go over a little? I'm not sure how long the discussion is going to last but I have a feeling it's going to be a little bit more than --

DR. REISCHAUER: The longer the presentations take, the less the discussions will take.

MS. FARNSWORTH: I will try to help catch us up, because I've always been able to talk fast anyway.

HealthHelp is a radiology benefit manager that's really based on evidence-based medicine, quality and safety. We believe that methodologies that have resided in imaging in the past haven't worked or we wouldn't see the trends that we are seeing today. Within HealthHelp we see anything from 15 percent trends to one large Midwest BlueCross BlueShield plan that had a 40 percent trend in outpatient imaging. We have about 17 million lives in our data warehouse so we have a wonderful ability to look at different plans with different benefit design and that are doing different tools and see what is working best, and also see the feedback from those physicians that are interacting.

There certainly are programs -- we have seven standardized programs. We only have one plan that we for that is using all seven, because in certain geographic areas things are appropriate or things are not. I know that is something that's very hard for Medicare to deal with.

Our programs are focused on making sure that we get the appropriate procedure, and hopefully not with a hassle factor, but more on evidence-based, education, appropriate site of service, and the correct payment. We tell radiologists and other imagers, we certainly want to pay them for what they did, but it's very important that we don't pay them for what they didn't do.

One of these programs, as you can see on this slide is about provider privileging. I think we've all talked about it. I think it's becoming very important. Our programs are all evidence-based based on peer-reviewed literature, not the world according to us, which I think is very important. At any rate, it's specialty specific. We want doctors to be able to do those things that they were trained to do in their residency program. But if they haven't been trained to do them, we don't want them doing that.

An off-the-wall outlier example is we have a plan, one of our plans who actually has podiatrists reading MRIs, and they are having to reimburse that. That's a severe example but it's a lot of money, and these tests many times get done over because no surgeon or therapist is going to act on an exam that he doesn't feel was read by the right person.

So our provider privileging focuses on non-radiologist. We have discovered that the quality in a non-radiologist's office on equipment and on the professional read is very low. As a matter of fact this literature here points out that 10 percent to 35 percent of non-radiologists have an error in their imaging examination. Sixty percent to 90 percent of all non-hospital physician-based imaging is performed by non-radiologist. So when we look at our imaging costs and our spend, we have to look at the non-radiologists. Otherwise we're the tail wagging the dog; we're not hitting the biggest piece of our spend. And of course, we believe that all of this must be based on published literature and national experience.

What I did for you, and I'm not going to spend time on these numbers -- you have them and can look at them later -- is I used an example of one of our payers. They have 2 million PPO members, all fee-for-service like Medicare. They spent $709 million in outpatient radiology. None of these savings are based on inpatient. Their trend was 12 percent when we took on this task, and I wanted to show you what they saved by implementing different ones of these plans.

Provider privileging. We have certain areas that we don't believe any imaging privileges are merited based on the education of those physicians. Ones that do, and as you can see here, for this program was a $45 million potential savings. What we have shown here is a $27 million saving because we see that about 40 percent are going to the right doctor. So they're not eliminated, they're just going to the appropriate physician. So with that in mind, about a $27 million savings.

Site inspection. This is one that is just near and dear to my heart. I don't think Medicare enrollees or any citizens of our country should be exposed to some of the old imaging equipment and high radiation dose that we see. We've seen a lot of equipment that's pretty shocking that's used it physicians'

offices.

What we're doing is literally assessing the safety and technical quality of outpatient imaging facilities. This is a program that is not about high quality. This is about minimum safety. Just please keep our members safe. We provide objective information that we can use for participation and the technical component privileging. We then can assure our members and their physicians that the contract imaging facilities are safe. And it definitely complements provider privileging.

I'm showing you this from a plan. This was actually published and presented at the RSNA by our group and also published in Radiology by Dr. David Levin and Dr. Bill Oreson, a part of HealthHelp. This is interesting. This plan, they actually had a chiropractic vendor who had represented and warranted that all the imaging equipment was safe. We found podiatrists using old dental equipment to do toes. We found facilities that actually had no imaging equipment at all and were billing our payer. We found one internal medicine physician who the nurse said the chest machine hadn't been plugged in in four years. It didn't work, but they were showing a positive or a negative film to their patient and then billing our plan.

I will tell you that this plan is in the state of Utah, the healthiest state in our country. So this is not something where we're going to a place we expected to see poor imaging equipment. Remember, this is not what we would consider high quality. This is basic safety. Forty-nine percent of all chiropractors in the network did not pass. And unfortunately, we had one radiology group that didn't pass either based on old CT scanner that they had in the practice from the 1980s.

The savings opportunity here was pretty clear. This plan was adamant that their enrollees were going to be safe and they were going to meet certain minimum standards. You in Medicare have this type of thing, a precedent for this with mammography already that's overseen by the FDA. The savings opportunity for this plan was $5 million dollars and we certainly saw that -- really this was conservative because it was based on a 5 percent reduction. Most of our plans see something like 10 percent reduction in cost because of the certification.

We do do claims editing and claims review. We find that that's a very strong area to save money and it's certainly not -- we do use the CCIs as Kevin Hayes had referred to. But more than that, we've added a number of edits based on technology, changing technology. As an example I'll to you, when the CPT code for CT of the abdomen and CT of the pelvis were developed, those were two very separate exams. Today with ultra fast slip ring technology, that second exam might take an extra two minutes or three minutes. Does that radiologist expect to receive two payments? We haven't had any pushback when say, no, that's one

exam on the technical component.

So we have a lot of edits that we've added that are just based on all the good things that have happened with new technology that have now made our payment policy a little obsolete.

The savings opportunity in our plan here, if you look at the risk management edits, these are edits that have to do with paying a fraudulent claims inadvertently. So we consider that risk management because if you're working for an employer he's certainly not going to like you spending his money that way. The policy edits that I had referred to earlier, combination edits, those edits are all based on technology, not on medical necessity. The savings opportunity here was $48 million, $49 million. The savings that we projected was $31 million, assuming that the plan might only take 40 percent of our policy edits.

We are big believers in consumer education. We believe that citizens of our country, enrollees in our plan are our partner, and when we can get information to them they will vote with their feet. They want to know and they will study and they'll read. Some of our plans have actually used this for benefit design as well. This program is called Rad Aware. It's written at the sixth-grade level. We actually had teams of sixth-graders take it and pass the test and understand it.

So one of the things that we're teaching is that imaging is good. It's great to have your mammography. You need to do that. We also talk about the fact that asking for, as Miriam pointed out, a full body CT is not what you want because the radiation load you're getting and also the false positives that you might have that frighten you and lead you down a path that spends a lot of money.

So we want patients to participate with their doctor in these imaging decisions and have some thinking. They have a right to ask, is a radiologist going to read my exam? They have a right to ask, has anyone accredited this facility? We want them to know that.

Our savings opportunity here we're never going to know, but just a conservative guess, if there were only two scans per doctor per month that were not done because a patient asked for it and those only cost $100, a national opportunity for savings here is $400 million. I think you who are physicians know that two scans not done per month at $100 each is pretty low. But Rad Aware for enrollees, we have found has been very important.

We also show the enrollee knows what his copay is when he schedules his exam, he understands what his copay his, and he understands it's different many times based on where he goes to have his exam.

Physician proficiency in ordering. We think a highly-educated ordering physician panel will get way in front of the

power curve as far as trends. Instead of the hassle factor -- and this is why we're friends anyway. We're sparring a little bit -- is that instead of the hassle factor of calling and asking, what if you knew already, because you actually took an online exam?

So we have an online ordering physician exam, four hours of CME credit, all based on evidence-based literature. You can't fail because it's multiple choice. You click on the pdf file, read the peer-reviewed literature. It has the answer in it. Then answer the question. It's actually scored while you take it so you can see if you're -- what we see is the first two or three they miss because they're not reading because they think they know this already. Then the rest of them, they start reading and they pass.

So it teaches things like only use imaging when it's going to influence your clinical decisionmaking. If you are going to do imaging but you're not going to do surgery anyway, then why do it? Instead of ordering the multiple exams, only order one.

Summary of our solutions, just to take clear you quickly through that. The problem, the solutions and the lessons that we've learned. I think we all have stated that self-referral leads to over-utilization. We see it in the data. We've seen it in the studies that the GAO had done in Florida.

The solution. Criteria for physician privileging based on evidence-based literature.

Lessons learned. You can save, in this example I gave you, a lot of money. The quality of imaging facilities varies widely, and it's a safety issue. It's important. When the bad actors go away you save a lot of money.

Loose rules on claims payments. We need to tighten those rules and make sure that we're spending our money wisely, just like we do in other areas.

Patient demands waste exams. So consumer education. The correct exam is not always ordered. We love our Rad Excel program. We find the ordering physicians like it, and we do give incentives, or our plans often give incentives around a higher reimbursement if you have taken this exam. You can afford to do that. One of our plans actually is giving a flat $300 if you take the exam. Talk about the return on investment. If he just ordered one less CT next year, it's huge.

And ordering MDs need to be empowered with updated information. They can't keep up with it all and they need to have this in front of them.

I'm going to end with that and we can move on to the questions.

DR. REISCHAUER: Thank you. We'll begin with Ralph.

MR. MULLER: Thank you to all three of you for this array of fascinating information. One of the ones that probably was most

alarming to me is the facility failure rate and I want to explore that chart with you a little bit more because I'm a little surprised that based on the failure rates you have on that chart which go 7 percent to 40-some percent, that the savings that you estimate is only about 5 percent. That surprises me.

Second, I would say, when you have the kind of proliferation of imaging to places that are not as traditionally regulated and scrutinized and you show that in one of your other charts, and you combine that with the consequences of self-referral and I think Dr. Ruane and Miriam also talked about how the incidence is higher, and this is known in national studies when the people ordering it own part of the facility and so forth.

So first I'd just like to get the facts, why is only a 5 percent savings on the facility failure rate. But then maybe speak a little bit more -- it strikes me when sometimes we're talking about how the market model may save more in terms of -- than the regulatory model, there seems to be some evidence here that regulating these facilities more fully the way other institutions that are more used to being regulated, may have some real power. And especially when you put that together that in many of these facilities that have conflicts of interest in terms of ownership and so forth.

So maybe any one of you or maybe Cherrill first can -- maybe you can speak to your chart first and then maybe you can all speak to the coming together of these non-regulated facilities with a complex of interest in ownership.

MS. FARNSWORTH: The 5 percent that you saw, there was a 180-day right to cure, so some folks did cure, which is good.

MS. DePARLE: What does that mean?

MS. FARNSWORTH: We actually had a course on CD that we gave to everyone on how -- if your failure was this, this is what you do to cure it. We let them correct it. It wasn't punitive. All we're asking them is to be safe.

MS. DePARLE: So correcting it means changing their equipment, or what would they do?

MS. FARNSWORTH: Changing their equipment.

MS. DePARLE: Because if they did a read wrong, it's wrong.

MS. FARNSWORTH: Exactly. If they did a read wrong, it's wrong. But this is equipment, so it would be replacing a piece of equipment. I think the state of Utah, there are many physicians that have the money to do that. I don't think we would see that on a national basis. But 5 percent of your imaging spend is a lot of money.

DR. REISCHAUER: But also the fraction of all services delivered by radiologists is probably very hot and they have the lowest rates, so there's a weighted average of these failure rates.

MR. MULLER: Bob, one of the other charts points out that

when it goes to the distributed settings, then in fact it's not -- the radiologists are the ones in institutional settings. But by and large, once you go to these distributed sites -- I have to see what table it is -- then in fact it's these other people who start doing the imaging much more fully. I can't remember whether it's Tom's or Miriam's tables that indicated that.

DR. RUANE: If I could just comment on that as well. Really I think the market is always important and I think that if you take the approach that you are going to cut fees or not allow fees to increase for professional services like evaluation and management codes, this is exactly where the increased payments comes up, with more frequent tests.

We actually had an inspection and accreditation program initially and we found out because of the size of our plan, when we found really bad equipment doctors bought new equipment and had to support that. If you want the kind of doctor that's doing toe x-rays with a dental machine to buy new equipment and have to pay it off, I think that's the balance of where you get to with that. But I think all of us agree that this type of safety needs to be addressed, but the economics are difficult.

MS. SULLIVAN: I would also agree because I think one of the benefits that we have found is that by expanding the freestanding imaging facilities, increased competition, less desire for the physician groups to purchase this, and also incent them so perhaps it isn't the revenue stream that they were doing by the volume, but getting them to subscribe to the quality and the evidence-based guidelines that there can be some win-win where they're going to be able to be benefitted for following those protocols without just having the proliferation and having the capacity issues that we see.

MR. MULLER: Also just as a follow-up, I'd like to have you -- I think you're commenting on where I see the convergence of the distribution of the imaging equipment, especially to be people where there may be some real incentive to higher use through self-referral. I would also -- I think we discussed a year or two ago, and I don't know whether you have estimates, as to how much the cost of imaging equipment is going down and some kind of -- obviously, it's hard to think of this as a weighted average, but there have been -- this is one of the areas in which in fact the technology is considerably less expensive than it was four or five years ago. I know at least some of the large companies, the GEs, the Siemens and so forth, seem to have an aspiration to put one of their imaging devices in every doctor's office in America.

So I thin that will continue to occur and therefore we'll have these two factors working together.

MS. ROSENBLATT: My question is for Cherrill. Your slides weren't numbered but there's a slide that shows a savings

opportunity projected PMPM of $35.83, which I find astounding. Was that a Medicare population, a commercial population? And what's included in that number?

MS. FARNSWORTH: It's a commercial population. It's not Medicare. And it's on the slide that's titled what? Under which program?

MS. ROSENBLATT: It says, imaging facility technology certification.

MS. FARNSWORTH: This is on the site accreditation process, the facility accreditation process. Most of the money in this particular situation was in non-radiologist offices that did not have equipment and the savings, as we pointed out, is huge. But not only that, the patient safety issue is a big one.

MS. ROSENBLATT: So is this a fraction of the total membership then?

MS. FARNSWORTH: Of this plan?

MS. ROSENBLATT: Yes.

MS. FARNSWORTH: This is the PPO line of business in this plan.

MS. ROSENBLATT: The total PPO membership?

MS. FARNSWORTH: Right, 2 million lives.

DR. ROWE: If I can help, here's I think the problem that Ms. Rosenblatt may be having, and that is that if this is a commercial population with a total PMPM of $200 per member per month and you're going to save $35 per member per month, that's 17 percent, which is 7 percent more than the total cost of imaging. So that not only is all imaging disappearing but you're saving twice as much as you would if all the machines were thrown out. So you have to have the same number of protons and electrons or something here. You can't do this unless the PMPM is $400 or $500 per month, in which case it wouldn't be a commercial population.

MS. ROSENBLATT: That's why I asked.

MS. SULLIVAN: I think the other component, and maybe this is in relationship to that, that we found in evaluating the vendor programs and we solicited the experience of 15 plans throughout the country, and we found that the plans who had percentage off or discounts, more indemnity-based networks saw significant savings, and part of that was just steerage to lower-cost facilities. That definitely helps to bring this --

DR. ROWE: Ms. Sullivan, we're not questioning that. We're questioning, if I'm spending $15 on something, you can't tell me I'm going to save $25 on it by using your program.

Do you guarantee this savings?

MS. FARNSWORTH: We have performance penalties in our contracts. But if you look at this, the projected spend is $949 million. The savings is $5 million.

DR. MILLER: So the PMPM isn't necessarily the savings

number.
MS. FARNSWORTH: No, the projected PMPM is the gross amount --
DR. ROWE: So what is the savings on a PMPM basis? MS. FARNSWORTH: There are 2 million people in this plan --
DR. MILLER: It will be roughly 5 percent of $35.
MS. FARNSWORTH: Exactly. I'm sorry, the projected PMPM is if you did not put this program in place.
DR. ROWE: PMPM for what? Is this radiology or all health care services?
MS. FARNSWORTH: All modalities in imaging.
DR. ROWE: Just imaging.
MS. FARNSWORTH: In imaging. So chest x-rays through PET scans; mammography.
DR. MILLER: So the way I read this slide is $35 per member per month in imaging. Then you go through the multiplication to get the total spend, and then you take 5 percent in savings.
MS. FARNSWORTH: Exactly.
MS. ROSENBLATT: But $35 is a very high PMPM for imaging.
DR. ROWE: It's a very high number for a commercial population.
MS. FARNSWORTH: This is a plan that has a lot of indemnity. It's a large Blue plan with a lot of indemnity work. And it's in a state that we believe, and this plan actually ended up believing, that the consumers were driving a lot of these costs.
DR. ROWE: Are these savings net of your expenses and your charges --
MS. FARNSWORTH: Yes.
DR. ROWE: -- or are these before?
MS. FARNSWORTH: Net of our fees.
DR. NELSON: And they pay chiropractors [inaudible]?
MS. FARNSWORTH: Right. Mostly self-insured employers. Mostly indemnity. It is not a CON state so there's lots of equipment everywhere. Clearly they had to do something about their imaging costs.
DR. ROWE: Moving on, just a couple observations. One is nomenclature, which I thought was kind of interesting and almost sad in a sense. But Ms. Sullivan said -- it was interesting -- we're concerned that too many patients are being scanned with the machines and she said that one of the things that she was doing was they were going out and scanning the machines. So not only are we scanning the patients but we're scanning the machines. We should use a different word there. It sounds like we've got machines scanning machines.
But I think that's an interesting difference between, or a subtle point here on precertification that everybody should be aware of, because physicians are allergic to precertification because it's telling them how to practice medicine and they don't

like that. I understand that.

But one of the ways that this is done in some plans, I think, is that you don't have to do necessarily precertification as long as you do prenotification. That is you say to the physician, okay, you can order that procedure on that patient but you have to call us and tells us you're doing it. At which point -- it's not like you have to get our approval, you just have to notify us.

When that phone call comes in then the health plan can say, thank you, doctor, and by the way, the radiologist in our network with whom we have a contract who is closest to that patient's home address is doctor so-and-so and we want you to send the patient to that doctor for this scan. Because one of the major drivers of cost here, as was included in one of Ms. Sullivan's slide is leakage, and one of the issues is steerage. So that if you have a network that you're contracted with at certain rates but the doctors are self-referring or referring to the doctor down the hall who's in their group or in their building who's not in your network, that is a source of a lot of the additional expenditures. You can actually influence that without necessarily precertifying as long as you can prenotify or somehow get the doctor or the patient on the phone before the test is done.

So that's a subtle difference but I think -- I don't know if you've had experience with that but I know at least one plan has had some positive experience with that.

MS. FARNSWORTH: We definitely do that. Not only do we at that time keep the patient in network but we also give him his differential copay, because in many of our plans, if they go to the hospital outpatient they have a larger copay and if they go to freestanding they have a lower copay. We also tell the patient -- this is including the enrollee in decisionmaking. We also tell the patient if they charge to park, if they're on a bus line, if they provide free transportation, their hours of operation. These things are really appreciated.

DR. RUANE: Just a quick comment. I think the two things are subtly different but they can merge, and a prenotification requirement that includes some clinical information and produces automatic approval if they're met becomes precertification. Also, no physician believes that he or she needs precertification, but many believe that their colleagues would benefit greatly. So again, it's one of those beliefs that needs some testing.

MS. FARNSWORTH: Another thing that we have done that I think is helpful is even though it's notification, as you said, Dr. Rowe, if the test does not look like it falls into appropriate exam, we're auto e-mailing and auto faxing out the peer-reviewed literature regarding what the right decision would

have been. We don't say no.

DR. ROWE: If I can just continue one more second. One approach that we've tried which has worked in certain geographies is a kind of redux approach. That is, we've gone to capitation.

What has happened is we have capitation contracts with large imaging groups and they get a capitation fee for all the Aetna patients in the area. So that when a doctor feels that he needs a CAT scan or an MRI of an elbow or a shoulder, he'll send a patient to one of our participating radiologists who's capitated. Then it's not us telling the doctor that he doesn't need an MRI of that shoulder; that a plain film of a certain view is really the right x-ray, or no x-ray at all. What's happening is a radiologist examines the patient who's in our network and then calls the referring doctor and says, Joe, I've seen Mrs. Smith and I've examined her knee and I know you ordered an MRI but this is the test you really need and that's the one we're going to do.

It's a little bit like when I was a practicing physician I didn't order an operation. I ordered a surgical consultation and the surgeon came and told me whether he thought the patient should be operated on, and if so, what operation they needed. I wasn't telling them what operation to do. I was an internist seeking advice. We'd like to get our physicians thinking, and I think in Medicare, Medicare should get their physicians thinking that they're getting advice from radiologists about what test is the test to be done rather than getting Medicare in between the referring doctor and the radiologist.

MS. DePARLE: Jack, does this mean that you will not reimburse the doc for doing it in his office? So under these arrangements in the geographies where you use them, they send them to the radiologist group?

DR. ROWE: Yes, I think in those geographies where -- I believe that that's the case but I don't know it specifically to be the case so I don't want to be quoted. And there are only so many geographies where we can find a big enough radiology group that confident enough, et cetera, and our volume and our market share is big enough so that we can develop a mutually beneficial arrangement to capitate. But where we do it, I think it controls costs and it improves quality.

DR. REISCHAUER: But you also have to monitor access because the radiology group has an incentive to, at the margin, choose somebody who's outside of your system because they get a benefit from that and they don't get any benefit from one more scan for your patient.

DR. ROWE: I think that's right. But you have some data available in an ongoing way to give you a sense of whether the utilization is appropriate.

What you really get is you get feedback from the referring

physicians saying, this is working or it's not. And many times they say, you know, I've learned a lot over the last six months in all these conversations with radiologists about which x-rays I've been ordering all these years and which ones I should have bee, and that feedback part is very positive.

DR. NEWHOUSE: Dr. Ruane said he was jealous or something like that of Miriam Sullivan working for a real managed-care plan. I think that probably you can square that for Medicare.

I was wondering if any of the three of you had any reflections on whether any of the techniques you talked about could be transferred into the traditional Medicare world or not.

MS. SULLIVAN: I think that probably the greatest opportunity is around payment restructuring. I think we all talked a little bit about things like continuous body part, looking at multiple procedures. I also think one of the things that we're really excited about in the Boston area is that meeting with the physician groups and the large IDNs, they're putting their own programs in place to say, we hear loud and clear what the options are out there. We did throw out some capitation arrangements, similar to what we do for lab services, and really looking at what is the best opportunity that we all have a role to play in this.

We've seen in one particularly large IDN, they've hired radiologists internally using the American College of Radiology guidelines, and depending on where their physicians within that IDN sit, if they are above the benchmark they need to consult with their internal radiologist. So I think we've seen success and put the onus on the particular physician group.

I think the other piece of it gets to the self-referral. I think if that continues, we start with x-rays and now with all of the other advanced imaging that we talked about, to the extent that that's allowed to continue and they set up that -- then I think it's just going to create monopoly situations and in that avenue it's only going to get worse.

But I do think, given the opportunity, that it's not punitive for physicians, but there is an upside for them, is where we feel we're going to be able to be successful going forward.

DR. RUANE: I'll let Cherrill comment on the precertification piece, but our key, I think our opportunity to really make a difference really relates to network management, really relates -- and there's two key things. One is the doctors really have to want to be in the network. So there has to be good payment. There has to be good provider relations. They have to get prompt payment. They have to be happy with that. They have to feel that they're being treated fairly. Then you have to connect that with the threat that they might not be able to if their behavior is not appropriate.

So I think that to my mind, I see in our commercial health plan the opportunity to improve the quality and cost is really more related to the privileging and profiling piece. But you do have to have those two components. The fees have to be such and the administrative simplicity has to be such the doctors really want to be in, and the health plan really has to have the authority to say, Dr. Smith, we have to part ways.

DR. ROWE: There's a really important point here I think that we shouldn't miss for Medicare. That is that much of the ability of a health plan to do this is related to its local market share. Of course, BlueCrosses have dominant local market shares.

DR. REISCHAUER: Medicare does pretty well with market share.

DR. ROWE: That's what I was going to say. And particularly when you look at the fact that utilization might be 3.5 times as much in a Medicare beneficiary as an average commercial beneficiary, that if there were ever a plan that should be able to implement these kinds of things, some of the inhibitions or impediments that health plans had, Medicare will not have because of the market share.

MS. FARNSWORTH: I think without question, I know the work that Medicare has done with the CCI coding issues has been a good experience. Adding edits regarding the technical area of radiology, you could build on that. I certainly think that privileging of the technical component and privileging of the professional components -- I know Medicare has had some experience through MSQA and mammography certification that we could build on with the technical privileging. The professional component privileging is a policy. So as long as it's evidence based, I think certainly having that in place is something Medicare could do.

The other thing that would be interesting to see is something like a consumer education program about imaging, like our Rad Aware. I think that Americans would really appreciate the fact that Medicare distributed information that they could learn about. The feedback we get on that is, this is the first time I felt like my health plan ever cared about me. Those kinds of things are excellent feedback that health plans love to get.

Even with the new Medicare Modernization Act there's some incentive for hospitals, a financial incentive for hospitals to report the quality indicators. Certainly doing something like education, benchmarking, profiling, or education of the ordering physician and giving an incentive; not a mandate but an incentive, a financial one I think could easily follow on to that over time.

DR. NEWHOUSE: Can I ask a follow-on? Does Medicare have the same kind of ability to decertify an unsafe radiologic

facility that it would in some other provider types? That is, we saw all of these failure rates, rights to cure and so forth.

MS. DePARLE: Some of this isn't even regulated by Medicare. It was at one point FDA.

DR. NEWHOUSE: But Medicare could say, to qualify for payment you have to meet such and such a standard or we deem such and such an entity to --

MS. DePARLE: Medicare could do that.

DR. NEWHOUSE: But does it? That's my question.

MS. DePARLE: We did something like this with DME suppliers, just doing site visits to them. But the FDA has some regulatory authority here, doesn't it, Mark? Or is it CDC?

MR. MULLER: The problem is, if I can just put it in empirical -- these sites are not necessarily inspected by the states. By and large, large facilities like hospitals are inspected by states, the joint commission, et cetera. These doctors' offices and so forth are by and large not necessarily inspected for that. So therefore, for Medicare to do it you first need that prior step of a local authority, usually a state, to go certify. Then Medicare could act on that, but by and large they're not inspected.

MS. DePARLE: I don't think you have to have that. We did it for DME suppliers. I think Medicare can go out -- it takes resources so it would take the QIOs or someone to go out and do it. But based on what I've seen on the quality here, I'm very disturbed by that.

DR. MILLER: I was keeping a list of what I thought Medicare can do, and that can be for another conversation. But on this specific point, I think you could talk about conditions of participation here, you could actually talk about things like failure rates and the types of standards that you would want and either have an organization deemed to look behind it, or you'd have to think about some element of, whether FIs, QIO, or whatever within the Medicare program. I think this is reachable on the safety standards. I think this is one of the easier things to do.

MS. DePARLE: I'll make just a quick point. I think this has been a great discussion so thanks to Kevin for putting it together.

I'm surprised that the correct coding initiative doesn't have any of these imaging related edits in it. That seems to me to be the low-hanging fruit, as it were. But the more provocative point out of all this to me is the self-referral issue. This discussion adds a gloss to that issue as I've always thought of it, because I've always thought of it as more of -- the policy against self-referral is really driven by concern about over-utilization and incentives that physicians may have, physicians or other practitioners may have to perform services

that aren't needed.

Here what we're hearing is something that's even more troubling, which is the quality of some of those services appears to be really questionable. So it wouldn't just be an issue of financial incentives and Medicare spending growth being higher than it should be, it's also a matter of the quality being -- looks pretty terrible.

I guess I am wondering, are there other analogs -- and like is maybe a discussion for later since you're back in the audience, but it seems to me that's something that came out of this that may be more difficult, Mark, if you did a list of the things we could do. But it sure seems to cry out for something there. I didn't realize that -- I hadn't really thought about it that any -- I assuming this is saying that any practitioner who's certified by a state and participates in the Medicare program can do any of these imaging procedures?

DR. MILLER: I think from Medicare's perspective that's pretty much the situation.

MS. FARNSWORTH: That's the situation across the country.

MS. DePARLE: That doesn't seem right to me.

DR. ROWE: [Inaudible.]

MS. DePARLE: They're doing some privileging and they're doing some things around it. We're not doing anything right now.

DR. NELSON: Is there any evidence that your programs wash over to other payers within the area? I would think that facility certification might lead some of the facilities with substandard equipment to close down, and that would benefit other payers? Or do they continue with substandard equipment?

The same might be said of prior authorization and privileging functions. Would other payers like Medicare benefit within the areas where you're operating? Is there evidence to that effect?

MS. FARNSWORTH: The evidence that we have is that it depends on the state, but I'll use the example of Florida. Where we have done site visits and a plan to chooses to not have this person on the panel for imaging, other think but not imaging, we find that they just do imaging with their other revenue sources. Because unfortunately the whole idea is you've got to get the payment made to pay for the equipment.

DR. RUANE: I think we do see spillover into our traditional product from the managed product that makes it hard to figure out what the benefit of the program is. I think none of us operates in a vacuum. We can't thank you enough for DRGs. They pay us every day in terms of how the hospital dynamics changed. So there always is spillover.

MS. SULLIVAN: I would just close in saying that with our privileging program we have clinical radiology staff that go out and do the site visits so we feel that that's an imperative part

of our program, to make sure that we don't have providers in our network that we would look to see that they are providing substandard care. That's really what we hope to maximize in the future.

DR. REISCHAUER: I, like Nancy Ann, am shocked by the quality safety issue and reflect on the fact that we almost everywhere in the United States inspect cars for safety, but apparently not imaging equipment when we allow Medicare patients to go to those facilities.

I want to thank all of you. I think this has been tremendously informative for us and we will study your slides further and be in contact with you I'm sure more as we go along formulating our positions, so thank you.